Alabama West Florida Conference of the United Methodist Church

Medicare Supplement Plan for Retirees

Effective January 1, 2012

450 Riverchase Parkway East

P.O. Box 995

Birmingham, Alabama 35298-0001

Customer Service:

1-800-538-2396 toll-free

Preadmission Certification:

988-2245 (in Birmingham)

or 1-800-248-2342 toll-free

Rapid Response:

988-5401 (in Birmingham)

1-800-248-5123 toll-free

Website:

www.BCBSAL.com

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MedSupp Health Plan

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WELCOME

All of us at Blue Cross and Blue Shield of Alabama pledge to you we will provide the best service we can in the administration of your group health care plan. This plan document summarizes your group's benefits. It also summarizes conditions, limitations, and exclusions to those benefits. There are sections explaining eligibility and defining certain words, too. Please be sure to read the entire document.

Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of INDEPENDENT Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

If you have any questions which the person at the Conference who deals with employee benefits cannot answer, please call our Customer Service at 1-800-538-2396 (toll-free).

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PURPOSE OF THE PLAN

This is a retiree health plan designed to supplement the amounts Medicare pays for some hospital, medical, and surgical services. The Plan is not designed to cover all the expenses that Medicare does not pay. You must be enrolled in Parts A and B of Medicare in order to receive any benefits under the Plan. This plan is self-insured by the Alabama-West Florida Conference of the United Methodist Church. This means that the Conference pays for all claims out of its own assets and does not buy an insurance policy to pay benefits under the Plan. Blue Cross is responsible for administering claims under the Plan; Blue Cross does not insure the benefits under the Plan.

Some words and phrases have specialized meanings when used in the Plan. These words and phrases are defined in the Definitions section of this booklet. Generally, although not always, a defined term has an initial capital letter. In order to fully understand your benefits under this booklet, you should familiarize yourself with these defined terms before reading the remainder of the booklet.

ELIGIBILITY

Retirees

Who is Eligible for the Conference Medicare Supplement (MEDSUPP)?

Clergy members retiring between January 1, 2001 and December 31, 2005 must have been continually enrolled and paying the monthly Retiree Benefit Stabilization Fund since January 1, 2001 to be eligible for the retiree Medicare supplement for clergy and spouse.

Effective January 1, 2006 clergy members must have been continually enrolled in the active insurance and paying the monthly Retiree Benefit Stabilization Fund, if applicable, for five (5) years prior to retirement to qualify for the retiree Medicare supplement for clergy and spouse.

In order for a lay employee to qualify for the retiree Medicare supplement for the employee and spouse, the lay employee must have been continuously employed in the Alabama-West Florida Conference for twenty (20) years and enrolled in the active insurance for at least five (5) years who are 65 years of age and have retired status. Church must continue to pay premium on church check.

HOW MEDICARE AND THE PLAN WORK TOGETHER

Medicare and the Plan work together. As a person enrolled under Medicare, you probably know that Medicare has provisions that require you to pay a deductible amount and some amounts of coinsurance. The Medicare deductible is that amount of health care charges that you are required to pay before you begin to receive Medicare benefits. The Plan pays for the Medicare Part A deductible, subject to the limitations under “Hospital Coverage” below.

Coinsurance is that portion of your expenses, for certain medical services, that the law requires you to pay after benefits begin. The Plan pays for Medicare Part B coinsurance and the Part A coinsurance that you would otherwise have to pay yourself for Medicare approved services.

Medicare deductible and coinsurance amounts change from time to time. When they do, your benefits under the Plan will automatically change to pay the coinsurance amounts only.

The Order in Which Benefits Are Paid

Your Medicare coverage always pays first. In order to collect these benefits, be sure to follow the instructions in Medicare & You, a free publication of the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA). Then, if you still have expenses left unpaid, your coverage under the Plan may pay them. Please see the instructions on how to file a claim that are printed near the end of the Plan.

You can obtain a copy of Medicare & You on the Internet. Go to www.medicare.gov to download a copy or obtain information on ordering a copy.

BENEFITS

All benefits are subject to conditions, limitations and exclusions of the plan, which are set forth later in this booklet.

Inpatient Hospital Services

The Plan will cover the Medicare Part A deductible amount and the Medicare Part A coinsurance amount for inpatient hospital services covered by Medicare for your hospital stay.

If you receive inpatient hospital services in a Non-Participating Hospital, the Plan will pay the coinsurance only if the services qualify as emergency hospital services covered under Medicare. See the “definitions” section at the end of the Plan to understand the distinction that the Plan and Medicare make between Participating and Non-participating Hospitals.

Additional Inpatient Hospital Services

It is possible that, during an extended hospital stay, your Medicare benefits may run out (including your lifetime reserve days as described in Medicare & You). If this happens to you, the Plan will pay for an additional 365 days of Medically Necessary inpatient hospital services and supplies, subject to the following:

- If the hospital has a contract with us, the Plan will pay the hospital the amount it has agreed to accept from us.
- If the hospital is a Non-participating Hospital, the Plan will pay for reasonable expenses.
- If the hospital is a Non-participating Hospital, the Plan will provide additional inpatient hospital benefits only if services qualify as emergency hospital services covered under Medicare.

Inpatient and Outpatient Blood Deductible

The Plan will pay the replacement fee charged by a hospital for the first three pints of whole blood or units of packed red blood cells in each year. Any blood deductible satisfied under Part B will reduce the blood deductible required by Part A. The Plan will also pay 20% of the Medicare allowable charge for blood under Part B of Medicare above the Part B deductible amount.

Outpatient Hospital Services

If you receive outpatient hospital services covered by Part B of Medicare in the outpatient department of a hospital, the Plan will pay the Part B coinsurance amounts not paid by Medicare but otherwise payable by you.

Outpatient services in a Non-participating Hospital are covered only if they are emergency services for which payment is made under Medicare.

COVERED MEDICAL EXPENSES

Covered medical expenses mean the expenses of the kinds covered by Medicare which are incurred by you and determined by Medicare to be reasonable and allowable for medically necessary services and supplies when performed or prescribed by a physician. The following are some examples of covered medical expenses:

- physicians' services for medical care and treatment and for surgical operations and procedures;
- radiation therapy and outpatient physical therapy services;
- x-ray, laboratory, and pathology services;
- prosthetic devices (other than dental) and orthopedic devices (except corrective shoes);
- medical supplies such as oxygen, splints, casts, trusses, catheters, colostomy bags and supplies, and surgical dressings;
- portable diagnostic X-ray services;
- durable medical equipment (not implantable);
- ambulance services; and,
- ambulatory surgical center services.

Covered Medical Services are considered to be "incurred" by you on the day the service is rendered or the supplies are furnished.

For any services covered by Medicare Part B, Medicare requires that you first pay an annual Part B deductible amount, after which Medicare pays 80% of the Medicare approved amounts, but not including the Part B deductible amount, and the Plan pays the remaining 20%. For mental and nervous services, Medicare covers 50% of the Medicare approved amounts after the annual deductible, and the Plan pays the remaining 50%.

Many providers of medical service do not accept the Medicare allowed amount as payment in full. These providers are generally described as not "accepting assignment." A provider who does not accept assignment may bill you for charges above the Medicare allowed amount – up to certain limits explained in Medicare & You. Such excess charges will not be covered under this Plan, and you will be responsible for paying them.

PRIVATE DUTY NURSING CARE BENEFITS

Limited to a lifetime maximum payment of $7,500.

This portion of the Plan is designed to provide medically necessary Private Duty Nursing Care benefits. You should note that Medicare does not cover Private Duty Nursing Care. This portion of the Plan therefore provides you with an additional benefit not covered under Medicare.

Private Duty Nursing Care must be rendered by a licensed professional nurse who neither is related to you by blood or marriage nor regularly resides in your household.

Important Note: Private Duty Nursing Care services must be precertified prior to the date the services are rendered. A precertification form must be fully completed and received by us at least three days prior to the date services are rendered. We will review the form, and if deemed appropriate, will approve the precertification in writing for a specific number of days and hours per day. If additional days are needed, you must have these days recertified. The recertification must also be received on the precertification form three days prior to the date services are rendered along with the nurses' notes from the initial period of treatment and a new nursing plan of treatment. If Private Duty Nursing Care services are not precertified or recertified, there will be no covered benefits.

Private Duty Nursing Care services are limited to a maximum payment of $1,500 during any 12-month period. The services must be certified by a physician as being medically necessary. Private Duty Nursing Care services are covered at 80% of the allowed amount. You are responsible for the remaining 20% of covered charges and any remaining balance in excess of the allowed amount. A period of nursing care begins the first day you require Private Duty Nursing Care services and ends on the day such services are no longer rendered.

SKILLED NURSING FACILITY BENEFITS

Skilled nursing facility benefits are provided by Medicare at 100% for the first 20 days. The next 80 days Medicare pays all but a per day coinsurance. The Plan will pay the coinsurance not paid by Medicare for you.

Admission must occur within 14 days after discharge from a hospital and the preceding hospital confinement must be at least three consecutive days duration for the same injury or illness. You must also receive personal visits by your physician for a minimum of once each 30 days as reflected by his medical records. To qualify, the facility must meet the definition of such a facility set out in the Social Security Act.

CONDITIONS FOR ALL BENEFITS

Plan In Effect

To qualify as benefits under this Plan, services, care, treatment or supplies must be provided while this Plan is in effect.

Medical Necessity and Reasonableness

For any service or supplies as to which no determination of reasonableness or necessity is made by Medicare, any benefits under this Plan will be paid only if we determine that the charges for them are reasonable and the services and supplies are medically necessary. See the definition of medical necessity near the end of this Plan for more information about these determinations.

Lifetime Maximum

There is a lifetime maximum of $7,500 on private duty nursing care benefits.

EXCLUSIONS

The Plan will not provide benefits for the following, whether or not a physician recommends or prescribes them:

1. Services or expenses which are excluded by Medicare, except for Private Duty Nursing Care services to the extent provided herein.

2. Services, care or treatment for which Medicare does not make a determination and which we determine not to have been medically necessary.

3. Services, care or treatment you receive before the effective date or after the end of the Plan. If you are in the hospital when the Plan ends the Plan will not provide benefits during the remainder of your hospitalization.

4. Services or expenses for cosmetic surgery not covered by Medicare. "Cosmetic surgery" includes any surgical procedure that primarily improves or changes appearance and does not primarily improve physical bodily functions or correct deformities resulting from disease, trauma, or congenital anomalies. Improvement of physical functions does not include improvement of psychological effects caused by physical defects or conditions. (See the section, Women's Health and Cancer Rights Act, for exceptions.)

5. Services or expenses not covered by Medicare for the care, treatment, filling, extraction, removal, replacement or augmentation of teeth or structures directly supporting teeth. "Structures directly supporting the teeth" means the periodontium, which includes the gingivae, dentogingivial junction, periodontal membrane, cementum, and aveolar process. Also excluded are periodontal care, prosthodontal care, endodontic care, orthodontic care, or any other dental care. Services or expenses for hydroxylapatite or any material with a similar purpose are also excluded.

6. Services or expenses that are paid for directly or indirectly by a governmental entity, except as otherwise required by Section 411.8 of the Medicare regulations.

7. Services or expenses in cases covered in whole or in part by workers' compensation or employers' liability laws, state or federal. This applies regardless of whether you file a claim under that law. It applies regardless of whether the law is enforced against or assumed by the employer. It applies regardless of whether the law provides for hospital or medical services as such. Finally, it applies regardless of whether the employer has insurance coverage for benefits under the law.

8. Services or expenses furnished by a Federal provider of services or other Federal agency, or furnished at public expense under Federal law or a Federal contract, except as otherwise required by Sections 411.6 and 411.7 of the Medicare regulations.

9. Services or expenses for routine physical examinations, convalescent care, rest cures, or sanatorium care.

10. Services or expenses for custodial care, meaning care primarily for providing room and board (with or without nursing care, training in personal hygiene or self care, or supervisory care by a physician) for a person physically or mentally disabled even if covered by Medicare.

11. Any medical or surgical treatment or procedures, any facilities, drug usage, equipment or supplies which are experimental or investigative (the meaning of which is explained near the end of this Plan).

12. Services or expenses for a claim not properly filed. You must file on proper forms all the information we need on or before December 31st of the year following the year services were received. Or, if you received services in the last three months of any calendar year, you must file by the end of the second year following the one in which services were rendered.

13. Hearing aids, eyeglasses, or contact lenses or for their examination or fittings. The Plan will pay up to the coinsurance amount for eyeglasses or contact lenses that replace the human lens function and are required by surgery in the eye or an eye injury defect. Our coinsurance payment in these cases is limited to one pair of eyeglasses or contact lenses or one pair of each if both are medically necessary.

14. Travel, whether or not recommended by a physician.

15. Private duty nurses and their board, except to the extent previously stated in the Plan.

16. Services or expenses for home health services or hospice, except for the 20% copayment for durable medical equipment.

17. Services or expenses of any kind covered under Part A of Medicare for a skilled nursing facility, nursing home, assisted living facility, or intermediate care facility, except as otherwise stated in Skilled Nursing Facility Benefits above.

18. Charges in excess of the and allowable charge under Medicare.

19. Any difference (due to federal law, regulations, or both) in the amount of Medicare benefits paid and the Medicare approved amount, except for co-insurance amounts covered by this contract.

20. Services or expenses incurred by a member with a physician or practitioner who has a private contract with the member under Section 1802 of the Social Security Act.

21. Medicare Part B deductible.

22. Prescription drugs.

23. Services or expenses for treatment of injury sustained in the commission of a crime (except for treatment of injury as a result of a medical condition or as a result of domestic violence) or for treatment while confined in a prison, jail, or other penal institution.

24. Services or expenses for, or related to, **sexual dysfunctions** or inadequacies not related to organic disease (unless the injury results from an act of domestic violence or a medical condition) or which are related to surgical sex transformations.

FEES

Payment of Fees for Coverage

As a retiree, you must pay for some or all the cost of coverage for yourself and your covered dependents. The Conference determines how much your contribution will be. The Conference may change at any time the amount that you are required to contribute.

GENERAL INFORMATION

Plan Changes and Plan Termination

The Conference reserves the right to amend, modify, or terminate the Plan at any time for current or future retirees or both. Amendments to the Plan are made by officers of the Conference to whom the Conference has delegated the power and authority to amend the Plan. Amendments to the Plan are communicated to you by means of a new summary plan description or summary of material modifications.

Providers of Services

We are not responsible for any acts or omissions by any institution or individual provider in furnishing any service, care, treatment, or supplies to you. Nor are we responsible if any provider of service refuses to admit or treat you or provide services to you. This Plan does not require us to do anything to enable providers to furnish services or supplies to you.

Benefit Payment Options

We, at our option, may pay any benefits under the Plan to you or to the hospital, physician or other provider who furnishes services or supplies. And our payment, either to you or to the provider, will fully perform our obligation under the Plan. But neither this nor any other provision in the Plan gives to any provider of services or any other person any right to recover any payment from us.

If you die or become incompetent, at our option we may pay your estate, your guardian or any relative we feel is equitably entitled to payment. Such payment will fulfill our obligations under the Plan, because this Plan is for your benefit alone and not for the benefit of any provider or any other person.

Responsibility for Filing Claims

Before we provide benefits under this Plan we must receive a written claim for benefits under the Plan and, when applicable, a Medicare Explanation of Benefits. You must submit claims with all the information we need on the forms we require. We may ask you for more information. If we do, you must provide any information we request so we can decide whether services, care, treatment or supplies were medically necessary and otherwise covered and entitled to payment of benefits under the Plan.

Because Medicare is your primary insurance and this Plan provides Medicare supplemental coverage, all claims must first be filed with Medicare before filing for benefits under this Plan. We cannot return claims to you or send them to Medicare if they are first sent to us by mistake.

Information from Providers of Services

Any hospital, physician, or other provider of services for which benefits under the Plan are claimed must furnish to us any requested information considered by us to be necessary or appropriate to the processing of your claim or to the performance of any provisions of the Plan. In addition, any provider furnishing services for which claim is made by or for you shall be deemed to be bound by provisions of the Plan.

Legal Options

No legal action may be brought against us unless, as a condition precedent, you and any provider furnishing services for which benefits under the Plan are claimed, both have fully complied with the provisions of the Plan.

Governing Law

This Plan is governed by the law of Alabama.

Women's Health and Cancer Rights Act

This Notice is required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) to inform you, as a member of the Plan, of your rights relating to coverage provided through the Plan in connection with a mastectomy. As a Plan member, you have rights to coverage provided in a manner determined in consultation with your attending physician for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications to produce a symmetrical appearance; including lymphedema.

This coverage is subject to this Plan's deductible and copayment provisions and all other terms of this Plan. Keep this notice for your records and call your Plan Administrator for more information.

PRIVACY OF YOUR PROTECTED HEALTH INFORMATION

The confidentiality of your personal health information is important to us. Under a new federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations and to put in place appropriate safeguards to protect your protected health information. This section of the booklet explains some of HIPAA's requirements. Additional information is contained in the plan's notice of privacy practices. You may request a copy of this notice by contacting your employer's human resources office.

Disclosures of Protected Health Information to the Plan Sponsor:

In order for your benefits to be properly administered, the plan needs to share your protected health information with the plan sponsor (your group). Following are circumstances under which the plan may disclose your protected health information to the plan sponsor:

- The plan may inform the plan sponsor whether you are enrolled in the plan.
- The plan may disclose summary health information to the plan sponsor. The plan sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The plan may disclose your protected health information to the plan sponsor for plan administrative purposes. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the plan.

Following are the restrictions that apply to the plan sponsor's use and disclosure of your protected health information:

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report to the plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of the booklet.
- The plan sponsor will allow you or the plan to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the plan must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow the plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or health care operations.
- The plan sponsor will make its internal practices, books, and records relating to its use and disclosure of your protected health information available to the plan and to the U.S. Department of Health and Human Services, or its designee.

- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor's custody or control that the plan sponsor has received from the plan or from any business associate when the plan sponsor no longer needs your protected health information to administer the plan. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of employees or other workforce members under the control of the plan sponsor may use or disclose your protected health information in accordance with the HIPAA privacy rules that have just been explained:

- **Treasurer**
- **Insurance Coordinator**
- **HRH of Alabama**
- **Benefit Development Group**

If any of the foregoing employee or workforce members of the plan sponsor use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions - which may include termination of employment. If the plan sponsor becomes aware of any such violation, the plan sponsor will promptly report the violation to the plan and will cooperate with the plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to you.

Security of Your Personal Health Information:

Following are restrictions that will apply to the plan sponsor's storage and transmission of your electronic protected health information:

- The plan sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations.

- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

- The plan sponsor will report to the plan any security incident of which it becomes aware in accordance with the HIPAA regulations.

Our Use and Disclosure of Your Personal Health Information:

As a business associate of the plan, we (Blue Cross and Blue Shield of Alabama) have an agreement with the plan that allows us to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required under HIPAA. In addition, by applying for coverage and participating in the plan, you agree that we may obtain, use, and release all records about you and your minor dependents that we need to administer the plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to us about you and your minor dependents that we need in order to administer the plan.

SUBROGATION OR REIMBURSEMENT

Right of Subrogation

If we pay or provide any benefits for you under this Plan, we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we have paid or provided. That means that we may use your right to recover money from that other person or organization.

Right of Reimbursement

Besides the right of subrogation, we have a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which we've paid Plan benefits. This means that you promise to repay us from any money you recover the amount we've paid or provided in Plan benefits. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay us. And, if you are paid by any person or company besides us, including the person who injured you, that person's insurer, or your own insurer, you must repay us. In these and all other cases, you must repay us.

We have the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you aren't made whole for your loss. This means that you promise to repay us first even if the money you recover is for (or said to be for) a loss besides Plan benefits, such as pain and suffering. It also means that you promise to repay us first even if another person or company has paid for part of your loss. And it means that you promise to repay us first even if the person who recovers the money is a minor. In these and all other cases, we still have the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to Recovery

You agree to furnish us promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce our rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorneys' fees charged you by your attorney for obtaining the recovery. If you do not give us that notice, our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

You further agree not to allow our reimbursement and subrogation rights under this Plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the Plan.

HOW TO FILE CLAIMS FOR MEDICAL SERVICES

1. When you go to the doctor or hospital, show both your Medicare Health Insurance card and your MEDSUPP I.D. card.

2. Claims must first be filed for processing with Medicare. If Medicare approves the service and your identification number is on the claim, the claim will generally be sent to us automatically for processing. Because this contract covers only Medicare-approved services, claims that are not approved by Medicare will not be sent to us for consideration. For private duty nursing claims you must submit claims with all the information we need on the forms we require. We may ask you for more information. If we do, you must provide any information we request so we can decide whether services, care, treatment or supplies were medically necessary and otherwise covered and entitled to payment of benefits under the Plan.

   IMPORTANT: If you or a relative is filing a claim, please be sure to first file your claim with Medicare before filing with us for benefits under this Plan. We cannot return claims to you or send them to Medicare if they are sent in error to us before Medicare.

3. You are responsible for paying any personal charges in the hospital for telephone, TV, private room, and other personal items. You are also responsible for the Part A deductible, the Part B deductible, any difference (due to federal law, regulations, or both) between the amount Medicare pays and the approved amount, and any charges not approved by Medicare.

The three simple procedures listed below should explain how to file your own claim.

1. Make sure your claim is filed with Medicare and wait until you receive your MEDICARE SUMMARY NOTICE form, also called an “MSN.”

2. Completely fill out a MEDICAL EXPENSE CLAIM form, number CL-438. (You can order blank claim forms from us.) Be sure to write both the Medicare Health Insurance claim number from your Medicare card and your MEDSUPP Plan Identification Number on the claim form.

3. Attach your Medicare MSN to your completed claim form and mail both forms to this address:

   Blue Cross and Blue Shield of Alabama
   450 Riverchase Parkway East
   Birmingham, Alabama 35244-2858

   We will send a Claims Report to you after your claim is processed.

HOW TO APPEAL DENIED CLAIMS

In General

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. We have developed a form that you must use if you wish to designate an authorized representative. You can get the form by calling our Customer Service Department. You can also go to our Internet web site at www.bcbsal.com and ask us to mail you a copy of the form. If a person is not properly designated as your authorized representative, we will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as medical necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

Appeals

If you are dissatisfied with our adverse benefit determination of a claim, you may file an appeal with us. You cannot file a claim for benefits under the plan in federal or state court (or in arbitration if provided by your plan) unless you exhaust these administrative remedies.

<u>In General</u>: The rules in this section of the booklet allow you or your authorized representative to appeal any adverse benefit determination. An adverse benefit determination includes any one or more of the following:

- any determination we make with respect to a post-service claim (i.e., a claim other than for a precertification of Private Duty Nursing Care benefits) that results in your owing any money to your provider other than copayments you make, or are required to make, to your provider;
- our denial of a pre-service claim (i.e., a claim for precertification of Private Duty Nursing Care benefits); or,
- an adverse concurrent care determination (i.e., we deny your request to extend previously approved Private Duty Nursing Care).

In all cases other than determinations by us to limit or reduce previously approved care, you have 180 days following our adverse benefit determination within which to submit an appeal.

<u>How to Appeal Adverse Benefit Determinations (other than a denial of precertification of Private Duty Nursing Care benefits)</u>: If you wish to file an appeal of an adverse benefit determination relating to a post-service claim (i.e., claims other than for precertification of Private Duty Nursing Care benefits), we recommend that you use a form that we have developed for this purpose. The form will help you provide us with the information that we need to consider your

appeal. To get the form, you may call our Customer Service Department. You may also go to our Internet web site at www.bcbsal.com. Once there, you may request a copy of the form.

If you choose not to use our appeal form, you may send us a letter. Your letter must contain at least the following information:

- the patient's name;
- the patient's contract number;
- sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available) (the best way to satisfy this requirement is to include a copy of your Claims Report with your appeal); and,
- a statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross Blue Shield of Alabama
Attention: Customer Service Appeals
P. O. Box 12185
Birmingham, Alabama 35202-2185

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

How to Appeal Pre-Service Adverse Benefit Determinations (a denial of precertification of Private Duty Nursing Care benefits): You may appeal an adverse benefit determination relating to a pre-service claim in writing or over the phone.

If over the phone, you should call 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free).

If in writing, you should send your letter to the address listed below:

Blue Cross Blue Shield of Alabama
Attention: Health Management – Appeals
P. O. Box 2504
Birmingham, Alabama 35201-2504

Your written appeal should provide us with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

Conduct Of The Appeal: We will assign your appeal to one or more persons within our organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires us to make a medical judgment (such as whether services or supplies are medically necessary), we will consult a health care professional who has appropriate expertise. If we consulted a health care professional during our initial decision, we will not consult that same person or a subordinate of that person during our consideration of your appeal.

If we need more information, we will ask you to provide it to us. In some cases we may ask your provider to furnish that information directly to us. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information. If we do not get the information, it may be necessary for us to deny your appeal.

We will consider your appeal fully and fairly.

Time Limits For Our Consideration Of Your Appeal: If your appeal arises from our denial of a claim other than the precertification of Private Duty Nursing Care benefits, we will notify you of our decision within 60 days of the date on which you filed your appeal.

If your appeal arises from our denial of a precertification of Private Duty Nursing Care benefits, and if your claim is urgent, we will consider your appeal and notify you of our decision within 72 hours. If your pre-service claim is not urgent, we will give you a response within 30 days. We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician tells us that your claim is urgent, we will treat it as such.

If your appeal relates to our decision not to extend previously approved Private Duty Nursing Care, we will make a decision on your appeal within 72 hours (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in all other instances).

In some cases, we may ask for additional time to process your appeal. If you do not wish to give us additional time, we will go ahead and decide your appeal based on the information we have. This may result in a denial of your appeal.

If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies: If you have filed an appeal and are dissatisfied with our response, you may do one or more of the following:

- you may ask our Customer Service Department for further help;
- you may file a voluntary appeal (discussed below); or,
- you may file a lawsuit in federal court under Section 502(a) of ERISA or in the forum specified in your plan if your claim is not a claim for benefits under Section 502(a) of ERISA.

Voluntary Appeals: If we have given you our appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination, you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal.

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), we will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. We will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, we will not impose any fees or costs on you as part of your voluntary appeal.

You may ask us to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

COBRA

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X). If COBRA applies, you may be able to continue coverage under the Plan beyond the point at which coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage may be offered to each person who is a "qualified beneficiary." Your spouse could become a qualified beneficiary if coverage under the plan is lost because of a qualifying event.

Not all group health plans are covered by COBRA. You must contact your employer to determine whether this plan is covered by COBRA.

COBRA coverage can be particularly important for several reasons. First, it will allow you to continue group health care coverage beyond the point at which you would ordinarily lose it. Second, it can prevent you from incurring a break in coverage (persons with 63-day breaks in creditable coverage may be required to satisfy pre-existing condition exclusion periods if they obtain health coverage elsewhere). And third, it could allow you to qualify for coverage under state law. For example, in Alabama you may qualify for coverage under the Alabama Health Insurance Program (AHIP). See the section Coverage Options After COBRA Ends for more information. You do not have to demonstrate evidence of insurability in order to qualify for COBRA coverage.

You will have to pay for COBRA coverage. Your cost will equal the full cost of the coverage plus a two percent administrative fee. Your cost may change over time, as the cost of benefits under the plan changes. If the employer stops providing health care through Blue Cross, Blue Cross will stop administering your COBRA benefits. You should contact your employer to determine if you have further rights under COBRA.

COBRA Rights for a Covered Spouse

If you are covered under the plan as a spouse of a covered retiree, you may elect to buy COBRA coverage if you would otherwise lose coverage under the plan as a result of any of the following events:

- the covered retiree's death; or
- the covered retiree's divorce or legal separation from his or her spouse.

When the qualifying event is a divorce or legal separation, you must timely notify the employer of the qualifying event. You must provide this notice within 60-days of the event or within 60-days of the date on which coverage would be lost because of the event, whichever is later. See the section called Notice Procedures for more information about the notice procedures you must use to give this notice.

The period of COBRA coverage will generally last up to a total of 36 months, provided that premiums are paid on time.

Notice Procedures

If you do not follow these notice procedures or if you do not give the employer notice within the

required 60-day notice period, you will not be entitled to COBRA.

Any notice of an initial qualifying event of divorce or legal separation that you give must be in writing. Your notice must be received by the employer or its designee no later than the last day of the required 60-day notice period unless you mail it. You must mail or hand deliver your notice to the employer at 100 Interstate Park Drive Suite 106 Montgomery, Alabama 36109. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period. Your notice must include a copy of the divorce decree. For your convenience, you may ask the employer for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

Electing COBRA

After the employer receives timely notice that a qualifying event has occurred, the employer is responsible for (1) notifying you that you have the option to buy COBRA, and (2), sending you the an application to buy COBRA coverage.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the plan, or (2), the date on which the employer notifies you that you have the option to buy COBRA coverage. An election to buy COBRA coverage will be considered made on the date sent back to the employer.

Once the employer has notified us that your coverage under the plan has ceased, we will retroactively terminate your coverage and rescind payment of all claims incurred after the date coverage ceased. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, we will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that we may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the plan. The only way your coverage will continue is if you elect buy COBRA and pay your premiums on time.

COBRA Premiums

Your first COBRA premium payment must be made no later than 45 days after you elect COBRA coverage. That payment must include all premiums owed from the date on which COBRA coverage began. This means that your first premium could be larger than the monthly premium that you will be required to pay going forward. You are responsible for making sure the amount of your first payment is correct. You may contact the employer to confirm the correct amount of your first payment.

After you make your first payment for COBRA coverage, you must make periodic payments for each subsequent coverage period. Each of these periodic payments is due on the first day of the month for that coverage period. There is a grace period of 30 days for all premium payments after the first payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim you submit for benefits will be suspended as of the first day of the coverage period and the processed by the plan only when the periodic payment is received. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA coverage under the plan.

Payment of your COBRA premiums is deemed made on the day sent.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under these tax provisions, "eligible individuals" can either take a tax credit or get advance payment of 65% of the allowed amount of premiums paid for qualified health insurance, including COBRA coverage.

Early Termination of COBRA

Your COBRA coverage will terminate early if any of the following events occurs:

- The employer no longer provides group health coverage to any of its retirees;
- You do not pay the premium for your continuation coverage on time; or
- After electing COBRA coverage you become covered under another group health plan that does not contain any exclusion or limitation on any pre-existing condition you may have or you have sufficient creditable coverage to preclude application of the new plan's pre-existing condition exclusion period to you.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the plan. For example, if you submit fraudulent claims, your coverage will terminate.

If your group stops providing health care through Blue Cross, you will cease to receive benefits through us for any and all claims incurred after the effective date of termination of our contract with the group. This is true even if we have been billing your COBRA premiums prior to the date of termination. It is the responsibility of your group, not Blue Cross, to notify you of this termination. You must contact your group directly to determine what arrangements, if any, your group has made for the continuation of your COBRA benefits.

Coverage Options After COBRA Ends

If you exhaust your COBRA coverage, you may be eligible for a conversion health contract from Blue Cross. Please contact Blue Cross to determine whether a conversion contract is available. Conversion contracts have more limited coverage than COBRA coverage.

You may also qualify for coverage under state law. You should call the state insurance department in the state where you live to find out if you have conversion rights.

By contrast, if COBRA coverage ends because you stop paying for it, then you will not have any further coverage under the group health plan and you will not be eligible to buy conversion coverage (if available) and you may not qualify for continued coverage under any applicable state law program.

If you have any further questions about COBRA or if you change marital status, or you or your spouse changes address, please contact the benefits coordinator at the employer through whom you are receiving COBRA. Additional information about COBRA can also be found at the website of the Employee Benefits Security Administration of the United States Department of Labor.

DEFINITIONS

The following terms used in this document have the meanings shown below.

Blue Cross: Blue Cross shall refer to Blue Cross and Blue Shield of Alabama.

Conference: The Conference shall refer to Alabama West Florida Conference of the United Methodist Church.

Experimental or Investigative: These terms refer to any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either we have not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice.

Hospital: For ease of reference, this booklet generally uses the word "hospital" to refer to a Participating Hospital. When we mean to refer to a Non-participating Hospital, we will be explicit. A hospital does not include a place primarily for convalescent care, for rest, homes for the aged, and does not include any school or college infirmary, sanatorium, nursing home or mental institution. Nor does a hospital include a facility that is primarily for the treatment of mental or nervous disorders.

Medically Necessary (applies only when Medicare has not made an applicable medical necessity determination): To be "medically necessary," services or supplies must be determined by us to:

(a) be consistent with the diagnosis and treatment of your condition,

(b) be in accordance with standards of good medical practice,

(c) not be for the convenience of you or your physician,

(d) be performed in the least costly setting required by your condition, and

(e) not be experimental or investigative (meaning that they are recognized by us as medically effective and, when required, have been approved by the Food and Drug Administration or any other governmental agency).

A "setting" would be your home, a physician's office, a hospital outpatient department, or a hospital when you are a bed patient. Only your medical condition (not your financial or family situation, the distance you live from a hospital, or any other non-medical factor) is considered in deciding which setting is required. As a patient's medical condition changes, the need for a particular setting may change.

"Medically necessary" is an especially important phrase because it is a basis on which benefits for services are provided or denied. Just because a service is prescribed for you does not automatically mean the service is "medically necessary" as described above. In an effort to make treatment convenient or to follow the wishes of the patient or the patient's family, a physician may suggest or permit a method of providing care that is not truly medically necessary. In all cases, if we determine that services you receive are not medically necessary, benefits for the services will be denied.

Medicare: Medicare means the programs established by Title XVIII of the Social Security Act, as amended.

Non-participating Hospital: This term refers to any hospital not participating in Medicare that is recognized or approved as a hospital by the American Hospital Association or the Joint Commission on Accreditation of Health Care Organizations.

Participating Hospital: This term refers to a hospital that participates in Medicare under an agreement with the Department of Health and Human Services.

Physician: The term "physician" means one of the following who is licensed and acts within the scope of that license at the time and place you are treated: a Doctor of Medicine, a Doctor of

Osteopathy, a Doctor of Dental Surgery, a Doctor of Medical Dentistry, a Doctor of Chiropractic, and a Doctor of Podiatry.

Plan: The Plan is the Alabama West Florida Conference of the United Methodist Church Medicare Supplemental Plan for Retirees. The Plan documents consist of the following:

- This benefit booklet, as amended;
- Our contract with the Conference, as amended;
- Any benefit matrices upon which we have relied with respect to the administration of the Plan; and
- Any draft benefit booklets that we are treating as operative. By "operative," we mean that we have provided a draft of the booklet to the Conference that will serve as the primary, but not the sole, instrument upon which we base our administration of the Plan, without regard to whether the Conference finalizes the booklet or distributes it to the plan's members. If there is any conflict between any of the foregoing documents, we will resolve that conflict in a manner that best reflects the intent of the Conference and us as of the date on which claims were incurred. Unless the context requires otherwise, the terms "Plan" and "contract" have the same meaning.

Private Duty Nursing Care: A session of four or more hours during which continuous skilled nursing care is furnished to you alone.

We: “We” shall refer to Blue Cross and Blue Shield of Alabama.

You: “You” and “your” refer to the person eligible for Medicare who signed the application for coverage.